

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Serenity Care Home	CHAPTER 100.1
Address: 94-1254 Kahuaina Street, Honolulu, Hawaii 96818	Inspection Date: March 13, 2018 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE OF HAWAII
DOH OHA
STATE LICENSING

18 OCT 23 AM 9:19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> Household member - No tuberculosis clearance.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Household member went to PCP to get his TB screening, TB screening put in my chart.</p>	<p>2-22-18</p> <p>19 FEB 22 P1:07</p> <p>RECEIVED</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> Household member - No tuberculosis clearance.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Documentation of the skin test & CXR is in my binder. To prevent this from happening again, I will use a check list to keep track of the expiration dates and check the checklist monthly for the expiration dates, and let my SCG, household members know 3 months before expire to make an appointment, and staple the Physical Exam and TB screening form together. And remind them to give me a copy once their done.</p>	<p>2-22-19</p> <p>19 FEB 22 P1:07</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p><u>FINDINGS</u> Current menu was not posted in the dining area.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I have posted a menu in the dining area.</i></p>	<p><i>3-14-18</i></p>

STATE OF NEW YORK
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18 OCT 23 19:19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p><u>FINDINGS</u> Current menu was not posted in the dining area.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again I will keep a meal menu posted in the dining area every week for all residents, I will continue to post the menu at least 2 weeks advance for residents view.</p>	<p>3-14-18</p> <p>18 OCT 23 09:19</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (e) Substitutes offered to residents who refuse food served shall be of similar nutritive value and documented.</p> <p><u>FINDINGS</u> Menu substitution not documented.</p>	<p align="center">PART 1</p> <p align="center"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p align="center">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p align="center">I have made sure that the menu has reflected an appropriate meal substitution if residents ask and has been documented.</p>	<p align="center">3-17-18</p> <p align="center">18 OCT 23 09:19</p> <p align="right">STATE OF HAWAII DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (e) Substitutes offered to residents who refuse food served shall be of similar nutritive value and documented.</p> <p><u>FINDINGS</u> Menu substitution not documented.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again, if resident will suggest a meal substitution, an appropriate meal substitution will be provided and will document it right away.</p>	<p>3-17-18</p>

STATE OF HAWAII
DOH-CHCA
STATE LICENSING

18 OCT 23 09:19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (e) A metal stem thermometer shall be available for checking cold and hot food temperatures.</p> <p>FINDINGS No metal stem thermometer to check cold food temperature.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>The new thermometer that I have now meets the standard requirements to check hot and cold foods.</p>	<p>3-20-18</p> <p>18 OCT 23 AM 19</p> <p>STATE OF CONNECTICUT DOH CHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (e) A metal stem thermometer shall be available for checking cold and hot food temperatures.</p> <p><u>FINDINGS</u> No metal stem thermometer to check cold food temperature.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I will put my my metal stem thermometer in a drawer with all my kitchen utensils that way I can see everything & everything I open the kitchen drawer, that is there.</p>	<p>2-22-19</p>

STAMPED
DATE: 02/22/19

19 FEB 22 01:07

PROCESSED

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><u>FINDINGS</u> Bleach was not secured under the kitchen sink in the resident's area.</p>	<p align="center">PART 1</p> <p align="center"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p align="center">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have placed the containers of bleach in a secured and locked area.</p>	<p align="center">3-17-18</p> <p align="center">18 OCT 23 AM 1:19</p> <p align="center">RECEIVED</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><u>FINDINGS</u> Bleach was not secured under the kitchen sink in the resident's area.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent a similar deficiency, I will educate my staff and household members about all toxic chemicals needs to be in ^{under the sink} the lock cabinet. I will check every day that the cabinet is lock.</p>	<p>2-22-19</p> <p>19 FEB 22 P1:08</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><u>FINDINGS</u> The key was in the lock of the medication cart upon entry into the ARCH.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I have placed the medication cart key in a secured area.</i></p>	<p><i>3-11-18</i></p> <p>18 OCT 23 A 9:20</p> <p>STATE OF MICHIGAN DEPARTMENT OF STATE LICENSING</p> <p>RECEIVED</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><u>FINDINGS</u> The key was in the lock of the medication cart upon entry into the ARCH.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I will educate my SCG's not to leave the key at the cabinet. I will check everytime I pass by to the medicine cart to make sure the key is not there.</p>	<p>2-22-19</p>

STAFF
 2/22/19
 1:08 PM

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 - "Acetaminophen 325 mg Give 650 mg by mouth every 4 hour hours as needed for mild pain/discomfort. Do not exceed 3 gms APAP/day" ordered 3/6/18; the label read "Take 1 or 2 tablets by mouth every six hours as needed for pain or fever. Max 8 tablets daily."</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I have corrected the MAR to reflect the corrected information.</i></p>	<p><i>3-14-18</i></p> <p>18 OCT 23 49:20</p> <p>STATE OF MICHIGAN DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 - "Acetaminophen 325 mg Give 650 mg by mouth every 4 hour hours as needed for mild pain/discomfort. Do not exceed 3 gms APAP/day" ordered 3/6/18; the label read "Take 1 or 2 tablets by mouth every six hours as needed for pain or fever. Max 8 tablets daily."</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again when the medications are delivered I will check the prescription order from PCP and compare with the medication label, and if its not matching I will call the PCP to clarify the order.</p>	<p>2-22-19</p>

STATE OF CONNECTICUT
DEPARTMENT OF
SOCIETY SERVICES

19 FEB 22 P1:08

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(2) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Recording of identifying information such as resident's name, social security number, racial extraction, marital status, date of birth, sex, and minister or religious denomination, and information about medical plan or coverage;</p> <p><u>FINDINGS</u> Resident #1 - Emergency Information Sheet was incomplete. The name of the physician, allergies, medical plan, medications were not recorded.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>I have placed the proper documentation on my care home binder.</i></p> <div style="text-align: right;"> STATE OF NEW JERSEY DEPARTMENT OF STATE LICENSING </div>	<p style="text-align: right;"><i>3-13-18</i></p> <p style="text-align: right;">18 OCT 23 09:23</p> <p style="text-align: right;"><i>RECEIVED</i></p>

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STATE OF CONNECTICUT
DEPARTMENT OF
HUMAN SERVICES

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> Resident #1 - No report of recent medical examination/hospitalization at the time of admission.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>the day following the inspection I went to tripler to obtain a copy of discharge summary.</i></p>	<p><i>2-22-19</i></p>

STATE OF CONNECTICUT
DEPARTMENT OF
HUMAN SERVICES

19 FEB 22 P1:08

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> Resident #1 - No report of recent medical examination/hospitalization at the time of admission.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again when I go pick up a resident admitting to my facility I will refer to the admission checklist to make sure all documents needed is all there if they give the papers in an envelope.</p>	<p>2-22-19</p> <p>19 FEB 22 P1:08</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #1 - "Blood glucose check BID Call MD if blood sugar less than 70 mg/dl or greater than 400 mg/dl" ordered 2/20/18; however, no blood glucose testing performed, glucometer and lancets available.</p>	<p align="center">PART 1</p> <p align="center"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p align="center">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p align="center"><i>I have checked the blood glucose as ordered and have documented.</i></p> <p align="right">STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p align="center"><i>3-14-18</i></p> <p align="right">18 OCT 23 A9:23</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #1 - "Blood glucose check BID Call MD if blood sugar less than 70 mg/dl or greater than 400 mg/dl" ordered 2/20/18; however, no blood glucose testing performed, glucometer and lancets available.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again during the admission if I see a glucometer & lancets, I will look for the order or contact NP to verify if BS checks are needed and get order.</p>	<p>2-22-19</p>

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
STATE LICENSING

19 FEB 22 P1:08

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h)(3) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><u>FINDINGS</u> One (1) light bulb out in the dining room fan/light fixture.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have checked the light bulb that doesn't work but there is only one bulb in there. No more other light bulb.</p>	<p>3-14-18</p> <p>18 OCT 23 09:23</p> <p>STATE OF HAWAII DOH-ORCA STATE LICENSING</p> <p>RECEIVED</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h)(3) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><u>FINDINGS</u> One (1) light bulb out in the dining room fan/light fixture.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again, if theres cases that theres broken bulbs in the house, will instruct SCG's, household members to report right away that way it will be fixed immediately.</p>	<p>3-14-18</p> <p>18 OCT 23 19:23</p> <p>STATE OF NEW JERSEY DOH-CHCA STATE LICENSING</p> <p>RECEIVED</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p><u>FINDINGS</u> Primary care giver (PCG) - No continuing education courses.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I the PCG have attended the required 12 hrs. of continuing education.</i></p> <p>STATE OF ILLINOIS DEPT. OF CHILDREN STATE LICENSING</p>	<p><i>3-31-18</i></p> <p>18 OCT 23 49:23</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p><u>FINDINGS</u> Primary care giver (PCG) - No continuing education courses.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again, I will start looking for inservices to attend. I will use a log to keep track of my inservices. I will check my log monthly so I know how many more I needed before the inspection. Once I'm done with my inservices I will put it right away to my calendar binder right away.</p>	<p>2-22-19</p> <p>19 FEB 22 P1:08</p> <p>STATE OF CONNECTICUT DEPARTMENT OF SOCIETY SERVICES STAFF LICENSING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p><u>FINDINGS</u> Substitute care giver (SCG) #1 - There was documented evidence of 8 hours of continuing education courses.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again I will instruct my caregiver to start attending in services early. I will check ^{use a} log monthly to keep track of the in services. I will check the log monthly so I know how many more they need before the inspection (12) - Once the in services completed put in the binder right away.</p>	<p>2-22-19</p> <p>19 FEB 22 P1:08</p> <p>STATE OF IOWA DEPARTMENT OF STATE LICENSING</p>

Licensee's/Administrator's Signature: Anabel Vila

Print Name: Anabel Vila

Date: 10-10-2018

STATE OF CALIFORNIA
BOH-DILA
STATE LICENSING

18 OCT 23 A 9:2

Licensee's/Administrator's Signature: Anabel Vila

Print Name: Anabel Vila

Date: 2-22-19

STATE OF CALIFORNIA
BOH-DILA
STATE LICENSING

19 FEB 22 P 1:08